A Comprehensive Approach to Improving Individual Medical Readiness for Shore Commands at Naval Base Point Loma: 2011 Update

Introduction

In June 2010, the Navy Bureau of Medicine and Surgery (BUMED) included Individual Medical Readiness (IMR) for Navy shore commands in the Performance-Based Budgeting (PBB) plan; thereby holding Navy medical treatment facilities accountable for the IMR of the Navy shore commands in their area of responsibility (AOR). The IMR for the shore commands at Naval Base Point Loma was stagnant at 45%; well below the Navy goal of 75% fully medically ready (FMR). Naval Base Point Loma is unique in that it has tenant commands located on six installations throughout the Point Loma area (including the branch health clinic which is a stand alone facility located off base). This geographical challenge and the lack of compliance at the individual and command level made it difficult to maintain the IMR of approximately 2,000 shore command personnel.

A team was assembled at Naval Branch Health Clinic Naval Training Center (NTC) in order to assess the situation and improve the IMR for the shore commands of Naval Base Point Loma. A comprehensive approach was implemented in a step-wise fashion with the objective of raising the IMR from its current plateau and ultimately to meet or exceed the 75% FMR goal. This approach was designed with the following initiatives: (1) address the proper population, (2) establish communication and a working relationship with that population, (3) provide the ability for the shore command liaisons, front desk personnel, and local dental clinics to check an individual's IMR status through the web-based Medical Readiness Reporting System (MRRS), (4) implement a walk-in PHA clinic, (5) promote the IMR project and progress through a waiting room display, and (6) gather appropriate feedback from these initiatives and provide continuous updates accordingly.

Methods

A team was assembled at Naval Branch Health Clinic NTC to improve the IMR metrics for the shore commands of Naval Base Point Loma. A comprehensive action plan was designed with the objective of increasing the IMR past the current plateau of 45%. The team consisted of eight highly motivated enlisted personnel and each was selected due to his or her experience with MRRS and/or good communication and organization skills. The first step was to identify each shore command, confirm they were located in the AOR, and confirm they were a shore command for the purposes of IMR (i.e., had no medical department and relied on the branch health clinic for their medical care). This is necessary to ensure the correct population is being targeted and tracked which can be difficult when dealing with tenant commands in multiple locations, on and off base. The shore commands were identified through base publications, personnel offices, and phone directories. This resulted in the number of shore commands for IMR tracking purposes actually

increasing from 36 to 39 unit identification codes (UIC's) due to the aforementioned criteria. The remaining commands were requested to provide a point of contact to serve as their medical liaison, and a directory booklet was compiled with the contact information of the chain of command and medical liaison for each command, as well as their corresponding UIC's.

Each team member was assigned to one or two commands, depending on size, and they initiated contact by email, phone, and/or in person to explain the IMR process and goals and to establish a relationship with each command. Each team member was instructed to maintain weekly communication with the medical liaisons in an ongoing effort to ensure compliance with IMR requirements, provide status reports, and assist with any problems. In addition, the team met together weekly with the team leader to discuss progress, any hurdles, and ideas for improvement.

To increase participation of the medical liaisons, they were each given reports-only access to MRRS. This allowed them to have real-time data to monitor their command's IMR and pull up delinquency and scheduling reports for action. The branch health clinic's front desk staff was given view-only access to MRRS and checked the IMR status of every sailor that reported to the clinic, regardless of reason. If the sailor was not fully medically ready, they were given a printout of their deficiencies and directed how to correct them before leaving the clinic (e.g., getting their immunizations, PHA, labs, etc.). Clinic staff members were directed to make every effort to make each sailor FMR while they were in the clinic, regardless of the reason for their visit. View-only MRRS access was also given to both dental clinics in Point Loma (at separate and distinct locations from the branch health clinic) so that the IMR status could be checked on each sailor reporting for their dental exam. This initiative was due to data mined from MRRS which revealed that approximately 32% of sailors who reported to Dental for their annual exam failed to report to Medical for their annual PHA.

The periodic health assessment (PHA) appointments were analyzed for no-show rates, access-to-care metrics, and patient feedback. As a result of this analysis, a walk-in PHA clinic was implemented with the intention to decrease the backlog of delinquent PHA's, make it more convenient to the customer by not having to wait for an appointment, and decrease the no-show rate for appointments. Patients still had the option to schedule an appointment with their own provider. The walk-in PHA clinic was supported by a full-time independent duty corpsman and supplemented as needed. If follow-up care was determined necessary during the PHA, the patient was referred back to his or her own provider for continuity purposes.

A waiting room display was constructed to promote the project and showcase the IMR status of each shore command. This was conceived in order to promote awareness and hopefully provide a basis for competition between commands. Finally, a feedback loop was implemented to monitor progress and customer satisfaction, as well as allow for any course corrections in the action plan. IMR data reports were generated weekly from MRRS for all 39 UIC's to track the progress, and

patients were given the opportunity to provide feedback on the new process on a comment card during their visit.

Follow-on improvements to the action plan in 2011 included: (1) ancillary clinics (e.g., Optometry, Physical Therapy) participating in checking IMR status, (2) "one-stop shop" PHA completion in one visit, (3) shore command leadership requiring IMR completion for leave/liberty requests, and (4) involvement of shore command fitness leaders to ensure PHA completion prior to participation in the physical fitness assessment (PFA).

Results

The directory booklet of the shore commands made it simple to keep track of their locations, liaisons, and associated UIC's. The booklets have been distributed to the staff and are updated periodically. Team members have trained other staff to assist and back them up as necessary. The team members and staff have made a competition between one another on their shore command's IMR performance. The medical liaisons at the shore commands were instrumental in getting their delinquent sailors over to the branch health clinic. The front desk personnel and dental clinics sent sailors daily to complete their IMR requirements, which could not occur before they had access to MRRS. The number of PHA's performed weekly increased three-fold. Patients were more compliant with coming to the branch health clinic as a walk-in. The PHA no-show rate decreased from 18% to 6% and attributed to the overall clinic no-show rate decreasing from 11% to 7%. The "one-stop shop" model improved PHA completion compliance and patient satisfaction. The active involvement of the shore command fitness leaders was instrumental in ensuring sailors had a current PHA before participating in the PFA which also improved the compliance rate. The waiting room display was a success and very popular with the sailors and the shore command leadership as a competitive tool. The data reports generated from MRRS were analyzed weekly and monthly for trends. Patient comment cards were evaluated for feedback, which provided for some adjustments in order to streamline the process; however, the feedback was overwhelmingly positive. Within eleven weeks of implementation the FMR rate of the shore commands of Naval Base Point Loma had improved from 45% to 65%. During the following four months, the FMR rate continued to improve peaking at 80% in April 2011, and has exceeded the 75% benchmark each month since.

Conclusion

This comprehensive approach met its objective by improving the IMR of shore commands at Naval Base Point Loma, exceeding the Navy goal of 75% FMR, and accomplishing this milestone for six consecutive months (April - September 2011). The action plan is sustainable; however, the walk-in PHA clinic is dependent on adequate staffing. This initiative could easily be replicated at other branch health clinics that are having difficulty improving the IMR of their shore commands.